IRO Express Inc.
An Independent Review Organization
2131 N. Collins, #433409
Arlington, TX 76011
Phone: (817) 349-6420
Fax: (817) 549-0310
Email: resolutions.manager@iroexpress.com

NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES: Aug/09/2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Lumbar (Caudal) Epidural Steroid Injection #1 with C Arm

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Anesthesiologist
Board Certified Pain Medicine

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

[X] Upheld (Agree)
[ ] Overturned (Disagree)
[ ] Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for <u>each</u> health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Pre-authorization determination 05/23/12
Pre-authorization determination 06/21/12
Pre-cert request 05/17/12
Office visit notes Dr. 01/11/11-07/09/12
Office note Dr. 04/17/12
MRI lumbar spine 09/08/11
EMG/NCV report 01/23/08
CT myelogram lumbar spine 02/12/08
Pre-cert request reconsideration 06/18/12
Procedure note lumbar epidural steroid injection caudal approach 12/28/10

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male whose date of injury is xx/xx/xx. The mechanism of injury is not described but the patient is noted to complain of low back pain and bilateral leg pain. An MRI of the lumbar spine on 09/08/11 revealed post-operative changes with anterior fusions with laminectomies at L3-4 and L4-5. Mild neural foraminal narrowing was noted on the right at L4-5. There was multi there was moderate multifactorial acquired canal stenosis and mild anterolisthesis at L2-3 which is increased compared to previous study of 01/05/07. Records indicate the patient also has a infusion intrathecal pump for drug delivery in place. Patient was seen on 05/14/12 with complaints of low back pain, bilateral lower extremity pain, left

foot swelling. Claimant reports Ultram and hydrocodone give some relief. On examination strength was normal. Lumbosacral spine pain was elicited by motion. Lumbosacral spine extension was abnormal. Claimant was recommended to undergo lumbar epidural steroid injection. A pre-authorization determination dated 05/23/12 recommended not denial of lumbar caudal therapeutic epidural steroid injection with C arm. It was noted that the claimant has undergone epidural steroid injection in the past, but there was no documentation submitted stating that the claimant had pain relief of at least 50-70% lasting at least six to eight weeks. The documentation submitted for review also did not state if the claimant has had any recent failed conservative treatment. It was further noted that guidelines suggest epidural steroid injections should be facilitated with a program of active physical therapy. Without documentation of the claimant's pain relief from last injection, failed conservative treatment in addition to epidural steroid injection, medical necessity is not established.

A reconsideration request for lumbar (caudal) epidural steroid injection with C arm was denied by pre-authorization determination dated 06/21/12. Claimant was noted to have undergone injection in the past which gave up to 70% relief for eight weeks; however, the documentation submitted for review did not include that the claimant had a decrease in pain medications or a functional response. In addition it is unclear if the claimant has failed recent conservative treatment. It is also unclear if the claimant has had a decrease in medication usage with last injection.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical data provided, the proposed lumbar epidural steroid injection with C arm is not supported as medically necessary. Claimant has a date of injury from xx/xx/xx. He apparently underwent anterior lumbar fusion at L3-4 and L4-5. Most recent imaging study submitted for review is an MRI dated 09/08/11 which revealed post-operative changes with interbody fusion at L3-4 and L4-5. Laminectomy is noted at these levels. At L5-S1 there's a mild disc bulge and mild facet hypertrophy. There's mild neural foraminal narrowing on the right at L4-5. There is no evidence of focal disc herniation or nerve root compression. EMG from 01/23/08 reported findings consistent with modest acute bilateral S1 radiculopathies, but unable to completely confirm radiculopathy because of inability to perform meaningful paraspinal examinations with multiple prior lumbosacral surgeries performed. The records submitted for review did not document that the claimant has had and failed a recent course of conservative treatment including physical therapy/home exercise program. Based given the current clinical data, the request does not meet Official Disability Guidelines criteria, and medical necessity is not established.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

[X] MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

[X] ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES